POC accepted 8/14/07 C. Miller Letterhead.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. BUILDING _____ B. WING _____	08/09/2007

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a Medicare recertification survey conducted at your facility on August 6, 2007 through August 9, 2007. The census at the time of the survey was 63. The sample size was 15. One complaint was investigated. Complaint #NV00015585 alleged a certified nursing assistant was physically and verbally abusive to residents on two separate occasions. The complaint was unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation it was determined that the facility	F 309	RECEIVED AUG 30 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA F 309 Resident # 6 – Corrected Resident will be medicated for pain prior to dressing changes. (see attachment F306 #6a)) Resident care plan updated to reflect resident behavior. (see F306 #6b)	8/27/07 8/27/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 7/30/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 failed to ensure adequate pain relief prior to wound treatment for 1 of 15 residents (Resident #6) and failed to ensure that a physician order was noted and carried out for 1 of 15 residents (Resident #5). Findings include: Resident #6: The resident was admitted to the facility on 11/27/06 with diagnoses that included Alzheimer's disease, hypothyroidism, hypokalemia, urinary tract infection, deficiency anemia, atrial fibrillation, cardiomegaly, pneumonia, diverticulosis, polymyalgia rheumatica, and subtrochanteric fracture with open reduction and internal fixation. The resident was noted by the facility staff to have a pressure ulcer on her right hip on 5/14/07. Record review revealed that the pressure ulcer had deteriorated to a Stage IV on 6/13/07. Record review revealed that in the social service progress notes written during the resident care conference on 12/14/07, the resident's family member had requested that Resident #6 be medicated for pain prior to therapy and sleep. Review of the facility's policy and procedure related to pain management revealed that "the patient has a right to effective pain management." During observation of wound care on 8/7/07 at 2:30 PM performed by LPN #1, Resident #6 complained of pain numerous times, saying "ow that hurts, ow, ow, ow." and pulled away from the nurse during the treatment of the pressure ulcer. When asked if she had premedicated the resident for pain, the nurse stated, "no, she doesn't really complain of any pain."	F 309	Residents with wounds have the potential to be affected by the deficient practice related to pain control with wound treatments. The corrective action is that licensed nurses will complete the 8/07 revision of "What you need to know pain management" study guide questions and competency by 9/18/07. (see attachment F309 6c) Monitoring will occur via weekly pain assessments for residents receiving ulcer care to be done with weekly measurements. Resident # 5 – corrected UA completed (see attachment F309 #5a) Dr. has requested another UA for 8/31 Residents have the potential to be affected by the deficit practice of failure to carry out physician's order for follow-up UA. The corrective action is that licensed nursing will be in-serviced (see attachment F 309 #5b) by the SDC or her designee on the follow-up UA order system by 9/18/07.	9/18/07 8/27/07 9/18/07

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F 309	Continued From page 2 Review of the nurse's education file revealed that LPN #1 had been educated on the importance of premedicating residents for pain prior to wound care on 9/25/06. On 8/8/07 at 7:30 AM, the Director of Nursing (DON) was interviewed. She stated that the facility is "working very hard to educate the nurses on the importance of medicating residents for pain prior to treatment and was not aware that this resident was not being medicated prior to wound care, but would look into it." Resident #5: The resident was admitted to the facility on 8/4/03, with diagnoses including dementia, hypothyroidism, depressive disorder, osteoporosis, chronic obstructive pulmonary disease, and pulmonary fibrosis. Record review revealed that, on 5/24/07, Resident #5 had been diagnosed with a urinary tract infection. An antibiotic and an in house urinalysis were ordered. The urinalysis was ordered to be done in 13 days on 6/5/07 and, if indicated, a culture and sensitivity study. Record review revealed no laboratory report of urinalysis results for 6/5/07. On 8/6/07 at 10:15 AM the Director of Nursing (DON) was interviewed. She reported that she would find the report if the lab had been done. At 11:00 AM she reported that the urinalysis had "not been done, and was missed because the nurse noting the order did not completely finish taking off the order." The DON also reported that the nurse noting the order was responsible for writing the order down on a calendar to alert the nurse caring for patient of the order on the date it	F 309	Monitoring will occur via weekday audits of physician orders by the MDS Coordinator or her designee.	8/30/07

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F 309	Continued From page 3 is to be carried out. Upon review of the calendar it was revealed that the order had not been written on the order list for the date of 6/5/07. On 8/6/07 at 11:10 AM, licensed practical nurse (LPN) #1 was interviewed. She reported that she "must have gotten called away while working on this order, and just forgot" to complete the process.	F 309		
F 314 SS=E	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that wound care was provided in a manner to prevent infection for 3 of 3 residents observed receiving wound care. (Residents #7, #3, and #6) Findings include: Resident #7: The resident was admitted to the facility 6/20/07 with diagnoses that included a pressure sore to her coccyx. An interview with the licensed practical nurse (LPN) #2, who was to perform the wound care on 8/6/07 revealed that the wound had been a Stage II, but the center had now opened resulting in a cavity with	F 314	F 314 Resident # 7, 3, 6 were re-assessed and orders or revisions implemented as necessary. Residents with wounds have the potential to be affected by the deficit practice of failure to ensure that wound care is provided in a manner to prevent infection. The corrective action is that licensed nursing will complete the dressing change competency by 9/18/07. (see attachment F314) Scissors will be dispensed to residents with routine dressing changes and placed in their individual treatment compartments. Monitoring will occur via random dressing competencies weekly times 4 and monthly times 2.By DON or her designee	9/18/07 9/4/07

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F 314	Continued From page 4 undermining. The wound was being packed with 1/4 inch gauze and Accuzyme ointment. The LPN stated the opening was just large enough to accept a cotton swab. A wound care treatment was observed on 8/6/07. It was observed that LPN #2 prepared a clean work surface on the bed in which she placed her supplies. The LPN applied a clean pair of gloves and started to perform Resident #7's wound care. At this time the LPN stated that although she had washed her hands in another resident's room, she felt she should have washed them before starting this wound care. She removed her gloves, went into the bathroom to wash her hands and then applied a clean pair of gloves. LPN #2 performed the wound care according to the physician's orders. The LPN changed her gloves between cleaning the wound and packing the wound. However, while packing the wound, LPN#2 made contact with the bed linen and the cotton swab tip twice. This occurred when the LPN was attempting to pack the gauze securely into the wound. At the completion of the dressing change, LPN #2 reached into her uniform pocket while still wearing the disposable gloves and removed a pen and a cigarette case while retrieving her scissors. She then placed the scissors on Resident #7's bed, but not on the clean surface she had prepared. LPN #2 used the scissors to cut the dressing gauze. She then placed the scissors back into her pocket. The dressing was secured with an adhesive bandage. LPN #2 then removed the pen from her pocket, wrote the date of the dressing change onto the dressing and replaced the pen into her pocket. At this point LPN #2 removed her gloves and went into the bathroom	F 314		

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F 314	Continued From page 5 to wash her hands. Resident #3: Resident #3 was admitted to the facility on 9/12/03 with diagnoses including aortic valve disorder, osteoporosis, constipation, dysphagia, and dementia with behaviors. During observation of wound care on 8/7/07 at 1:45 PM, LPN #1 entered the resident's room and washed her hands prior to performing any wound care. She donned clean gloves and removed the existing dressing. She removed the gloves, washed her hands and once again placed clean gloves on her hands. She then removed bandage scissors from her pocket and began to cut the bandage to size with the scissors. She returned the scissors back in her pocket, and placed the dressing over wound. She then removed her gloves and then placed tape over dressing with her ungloved right hand while holding dressing in place with her ungloved left hand. She washed her hands and left the resident's room. Resident #6: Resident #6 was admitted on 11/27/06 with diagnoses including Alzheimer dementia, hypothyroidism, hypokalemia, osteoporosis, gait abnormality, urinary tract infection, deficiency anemia, and atrial fibrillation. During observation of wound care on 8/7/07 at 2:30 PM, LPN #1 entered the resident's room and washed her hands prior to wound care. She placed clean gloves on her hands. She removed the existing dressing, and removed the gloves, washed her hands and applied clean gloves. She assessed the wound condition visually while bending down close to the wound. At that time her hair, fixed in a braid, fell into the wound	F 314		

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F 314	Continued From page 6 opening. LPN #1 placed her hair down inside the back of her uniform top with her left gloved hand. She proceeded to reach into her pocket and pull out the bandage scissors, and cut the packing gauze needed to pack the wound, to size. She placed the bandage scissors back into her pocket. She packed the wound with gauze, and pulled off her gloves and then placed gauze over the wound with her ungloved right hand, then held in place with her ungloved left hand, and taped the dressing in place with her right hand. Review of the facility's infection control policy and procedure titled "hand hygiene/handwashing," revealed that handwashing was to be done after contact with soiled or contaminated articles such as articles that are contaminated with body fluids, after resident contact, and after contact with a contaminated object or source, such as non-intact skin, body fluids or wounds, as well as, after removal of gloves. Review of the facility's policy and procedure titled "indications for glove use" revealed that gloves were to be worn when touching non intact skin of a resident, or when contact with blood or body fluids was likely.	F 314		
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the	F 371	F 371 Tray line observation No adverse effects were noted. The corrective action will be that kitchen staff will be in-serviced on proper food handling by food service manager or designee by 9/18/07. (see attachment F 371a)	9/18/07

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F 371	Continued From page 7 facility failed to ensure that food was served in a sanitary manner for the lunch meal of 8/6/07, and that pests were not present during the meal service. Findings include: Observation of the serving of the lunch meal on 8/6/07 revealed that the cook serving at the tray line left the line to get a bowl of cereal from another kitchen area returned to the tray line and programmed the microwave oven. The cook inserted the cereal into the microwave oven and started the oven. The cook did this without changing gloves or washing her hands when returning to the tray line. Observation in the dining room during the lunch meal on 8/6/07 revealed several flies in the dining room. At least two flies were observed landing on residents' food during the meal. Prior to the meal service, an exit door from the "A" wing nursing station leading to the backyard was observed to be propped open.	F 371	Tray line will be monitored for proper sanitary food handling by food service manager or designee weekly times four and then monthly thereafter. Dining room observation The corrective action is that pest control contractor was in 8/6/07 to spray exterior areas by exterior doors and a new "Gardner #GT-200 Bi-Directional Silent Bug Control System" has been installed in the dining room by the maintenance department. Signs will be posted on A and B wing doors exiting into the yard to keep doors closed.	8/6/07 8/29/07 8/30/07
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.	F 441	Monitoring will occur via random checks by staff. F 441 See F 314	

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F 441	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on wound care observation, it was determined that the facility failed to ensure that the development and transmission of disease and infection was prevented for 3 of 3 residents receiving wound care. (Resident #7, #3, and #6) Findings include: Resident #7: The resident was admitted to the facility 6/20/07 with diagnoses that included a pressure sore to her coccyx. A wound care treatment was observed on 8/6/07. It was observed that the LPN prepared a clean work surface on the bed in which she placed her supplies. The LPN applied a clean pair of gloves and started to perform Resident #7's wound care. At this time the LPN stated that although she had washed her hands in another resident's room, she felt she should have washed them before starting this wound care. She removed her gloves, went into the bathroom to wash her hands and then applied a clean pair of gloves. LPN #2 performed the wound care according to the physician's orders. The LPN changed her gloves between cleaning the wound and packing the wound. However, while packing the wound, LPN#2 made contact with the bed linen and the cotton swab tip twice. This occurred when the LPN was attempting to pack gauze securely into the wound. At the completion of the dressing change, LPN #2 reached into her uniform pocket while still wearing the disposable gloves and removed a pen and a cigarette case while retrieving her scissors. She then placed the scissors on Resident #7's bed,	F 441		

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F 441	Continued From page 9 but not on the clean surface she had prepared. LPN #2 used the scissors to cut the dressing gauze. She then placed the scissors back into her pocket. The dressing was secured with an adhesive bandage. LPN #2 then removed the pen from her pocket, wrote the date of the dressing change onto the dressing and replaced the pen into her pocket. At this point LPN #2 removed her gloves and went into the bathroom to wash her hands. Resident #3: Resident #3 was admitted to the facility on 9/12/03 with diagnoses including aortic valve disorder, osteoporosis, constipation, dysphagia, and dementia with behaviors. During observation of wound care on 8/7/07 at 1:45 PM, LPN #1 entered the residents room and washed her hands prior to performing any wound care. She donned clean gloves and removed the existing dressing. She removed the gloves, washed her hands and once again placed clean gloves on her hands. She then removed bandage scissors from her pocket and began to cut the bandage to size with the scissors. She returned the scissors back in her pocket, and placed the dressing over wound. She then removed her gloves and then placed tape over dressing with her ungloved right hand while holding dressing in place with her ungloved left hand. She washed her hands and left the resident's room. Resident # 6: Resident #6 was admitted on 11/27/06 with diagnoses including Alzheimer dementia, hypothyroidism, hypokalemia, osteoporosis, gait abnormality, urinary tract infection, deficiency anemia, and atrial fibrillation. During observation of wound care on 8/7/07 at	F 441		

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F 441	Continued From page 10 2:30 PM, LPN #1 entered the residents room and washed her hands prior to wound care. She placed clean gloves on her hands. She removed the existing dressing, and removed the gloves, washed her hands and applied clean gloves. She assessed the wound condition visually while bending down close to the wound. At that time her hair, fixed in a braid, fell into the wound opening. LPN #1 placed her hair down inside the back of her uniform top with her left gloved hand. She proceeded to reach into her pocket and pull out the bandage scissors, and cut the packing gauze needed to pack the wound, to size. She placed the bandage scissors back into her pocket. She packed the wound with gauze, and pulled off her gloves and then placed gauze over the wound with her ungloved right hand, then held in place with her ungloved left hand, and taped the dressing in place with her right hand. Review of the facility's infection control policy and procedure titled "hand hygiene/handwashing", it was revealed that handwashing was to be done after contact with soiled or contaminated articles such as articles that are contaminated with body fluids, after resident contact, and after contact with a contaminated object or source, such as non-intact skin, body fluids or wounds, as well as, after removal of gloves. Review of the facility's policy and procedure titled "indications for glove use" revealed that gloves were to be worn when touching non intact skin of a resident, or when contact with blood or body fluids was likely.	F 441		